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ARTICLE

EXPLOITATION OF THE ELITE: A CASE FOR PHYSICIAN UNIONIZATION

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I. INTRODUCTION

A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.[1]

This first principle of medical ethics sounds deceptively simple. The complexities are apparent, however, when this and other principles of medical ethics work in a system of managed health care. Under managed care, the issue is usually the cost of "compassionate" and "competent" medical care and not the care itself. This presents a difficult dilemma for physicians.[2] As one commentator has stated:

> [P]oliticians attempting to reform the health care system have promised that they will meet the contradictory goals of containing health care costs and increasing the number of people with adequate health care coverage.

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1. American Medical Association Policy Finder, *E-Principles of Medical Ethics* (Sept. 19, 2000), *available at* http://www.ama-assn.org.

2. *See* Pegram v. Herdrich, 120 S. Ct. 2143 (2000). "[I]n an HMO system, a physician's financial interest lies in providing less care, not more. The check on this influence (like that on the converse, fee-for-service incentive) is the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest." *Id.* at 2149 (citation omitted).

> Meanwhile, pre-paid health plans proliferate, advertising low costs and seemingly unrestricted benefits to prospective patients. Neither group wants to acknowledge the need to ration care. Thus, the easiest solution may be for politicians and third-party payers to avoid explicit acknowledgment of the need to ration, while creating policies that implicitly require physicians to ration at the bedside.[3]

This pressure from the government and managed care organizations ("MCOs") to "ration at the bedside" and consider cost as a component of care has serious implications for patients. Not surprisingly, the effects of cost-conscious utilization review led to a "managed care backlash,"[4] prompting policy makers to propose numerous "patients' rights" reforms seemingly designed to guarantee that patients can still have their health care like the old fee-for-service days, but maintain the cost-cutting that managed care seeks to deliver.[5] One of these proposals, the Quality Health Care Coalition Act ("the Health Care Act"),[6] emerged recently as a potential solution to the perceived problem of MCOs putting cost before patient care.[7] The Health Care Act would give physicians greater negotiating power against MCOs by allowing them to bargain collectively.[8] Many physicians as well as the American Medical Association ("AMA") support the proposal.[9]

One would expect physicians to support the Health Care Act based on managed care's profound effects on their practices. Long considered wealthy elites, physicians have not captured the sympathy of politicians or the American public in the managed care debate. Yet managed care's effects on them are no less significant than the effects of managed care on patients. Indeed, the lower reimbursements, which are a key part of managed care, have caused some physicians' practices to go bankrupt and have even driven some

3. Peter A. Ubel, M.D. & Robert M. Arnold, M.D., *The Unbearable Rightness of Bedside Rationing: Physician Duties in a Climate of Cost Containment*, *in* THREE REALMS OF MANAGED CARE, SOCIETAL, INSTITUTIONAL, INDIVIDUAL 170 (John W. Glaser & Ronald P. Hamel eds., 1997).

4. *See* David A. Hyman, *Managed Care at the Millennium: Scenes from a Maul*, 24 J. HEALTH POL., POL'Y & L. 1061, 1061-62 (1999) [hereinafter Hyman, *Managed Care at the Millennium*].

5. *Id.*

6. H.R. 1304, 106th Cong. (1999). The measure was passed recently by the House and awaits action in the Senate.

7. *See id.*

8. *Id.*

9. *See Statement of the American Medical Association to Congress, Testimony in Support of H.R. 1304, the Quality Health Care Coalition Act of 1999*, 106th Cong. 1 (June 22, 1999) (statement of E. Radcliffe Anderson, Jr., M.D., Executive Vice President and Chief Executive Officer of the AMA) [hereinafter *AMA Statement*], *at* http://www.ama-assn.org/ama/basic/article/0%2C1059%2C177-461-1%2C00.html.

physicians to leave the practice of medicine.[10] Further, many of our best and brightest may no longer be selecting a career in medicine.[11] Yet physicians largely do not support the unionization proposal on this basis. At the center of physicians' argument for collective bargaining rights is that such a step is necessary to ensure quality patient care.[12]

Opponents of unionization argue that allowing physicians to bargain collectively will not improve patient care, but will simply raise physicians' salaries and further compound the health care crisis.[13] The likelihood that either of these competing claims is true will not be examined here. Instead, this essay examines the physician unionization debate from the perspective of *physicians* as opposed to patients. Unlike a traditional worker seeking unionization, physicians, at least openly, do not argue that unionization is warranted because MCOs are exploiting them. This essay, however, assumes that they do for purposes of exploring whether such a claim might be warranted. The vehicle for this exercise is a hypothetical "moral motion to dismiss."[14] That is, taking physicians' arguments against managed care to be true, do they state a moral claim for collective bargaining rights? I assert that they do.

First, managed care has had a profound, negative effect on physicians' salaries and working conditions. Second, physicians are hesitant and in some cases unable to advocate on their own behalf. Third, the "free market" for health care, which government and MCOs purport to promote, is not so free at all. Taken together, these points illustrate that MCOs, in some cases, may have an unfair advantage over physicians, which MCOs are able to use to their significant benefit. Accordingly, physicians legitimately can make the claim that MCOs, with the support of corporations and the federal government, are to some degree exploiting them. Thus, physicians' argument for an antitrust exemption to allow them to bargain collectively has some moral basis, and should not be brushed aside as simply an attempt by wealthy elites to protect their position. While it may be that some exploitation of physicians is necessary and can be justified as being for the "greater good" of solving our health care crisis, in the long run, society will only benefit from seriously considering the impact health reform has on physicians.

10. Anne Barnard & Kathryn Tong, *The Doctor is Out: More and More Physicians, Frustrated with Managed Care, Are Trying New Professions and Finding Life Less Stressful*, BOSTON GLOBE, July 9, 2000, at A1.

11. *See* Daniel S. Greenberg, *USA's Changing Environment of Medical School Enrollments*, 352 LANCET 1531, 1531 (1998).

12. *See infra* text accompanying notes 76-81.

13. *See infra* text accompanying notes 82-94.

14. *See* WRIGHT & MILLER, FEDERAL PRACTICE AND PROCEDURE, § 1357 (1990) ("[F]or purposes of the motion to dismiss, the complaint is construed in the light most favorable to plaintiff and its allegations are taken as true.").

II. BACKGROUND

A. What is Managed Care?

Before explaining managed care's effects on physicians, it is important to explain the managed care system. The managed care system gained popularity as a way to curb steadily rising healthcare costs.[15] Thus, it is "a collective response on the part of both public and private payers to mounting evidence of out-of-control health care costs which threatened the future of health insurance . . . ."[16] Employers concerned about the costs of employee health benefits are key supporters of managed care, as they believe it will help reduce health care costs and make providers more accountable.[17] The government is also an important player in the success of managed care, through legislation[18] and in its role as a purchaser of health care services through the Medicare and Medicaid programs. Thus, it has been stated that "[c]ost reduction, not quality improvement, was the predominant motivation for the switch to managed care."[19] This focus on cost is significant not simply for employers looking to reduce health benefit expenditures, but for physicians as well. Before managed care, it was the physician who was "the locus and determinant of quality."[20] Traditionally, cost was not a concern in the treatment decision.[21]

The managed care system emphasizes the cost of health care services and attempts to control these costs through a variety of different techniques. In general, managed care is:

> [A]ny health coverage arrangement in which, for a pre-set fee (i.e., the premium), a company sells a defined package of benefits to a purchaser, with services furnished to enrolled members through a network of participating providers who operate under written contractual or employment agreements, and whose selection and authority to furnish covered benefits is controlled by the managed care company.[22]

15. DENNIS A. ROBBINS, INTEGRATING MANAGED CARE AND ETHICS: TRANSFORMING CHALLENGES INTO POSITIVE OUTCOMES 5 (1998).

16. RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 546 (1997).

17. ROBBINS, *supra* note 15, at 5.

18. *See, e.g.*, Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended in scattered sections of 42 U.S.C.).

19. ROBBINS, *supra* note 15, at 3.

20. *Id.*

21. *Id.*

22. ROSENBLATT, *supra* note 16, at 551-52; *see also* KENNETH R. WING ET AL., THE LAW AND AMERICAN HEALTH CARE 84 (1998) (The term managed care "can be used to include virtually any financing arrangement where there is third-party management or supervision that attempts in some structured way to oversee quality and, particularly, the costs of services delivered to the plan's beneficiaries.").

The "control" exercised by MCOs is in the form of "supply- and demand-side strategies to force patients and providers to consider the marginal costs in making health care consumption decisions."[23] Courts have noted that in this role, MCOs can wear two hats: providing administrative support for an insurance plan, including making determinations of eligibility or coverage, and acting "as an arranger and provider of medical treatment."[24] For instance, MCOs often require pre-authorization for certain services, restrict access to specialists, deny payment for services provided outside the "network," require co-payments, pay physicians on a capitated basis or offer bonuses tied to certain utilization levels and restrict coverage of prescription drugs, among other things.[25] In short, MCOs enforce utilization management by controlling physicians' behavior.[26] It is these types of controls that have led to the "managed care backlash" and concern over its effects on patients.[27] As mentioned above, however, the tools of managed care also have a significant impact on physicians.

B. Managed Care's Effects on Physicians

In evaluating the "claim" physicians might make against MCOs and whether it would survive a "moral motion to dismiss," we must first determine the basis of the claim. A moral claim by physicians is derived from managed care's effects on their professional obligations, working conditions and incomes. In general, physicians feel a loss of control over their practices.[28] Many physicians feel that the utilization management undertaken by MCOs is "oppressive" and unduly interferes with the physician-patient relationship by, for instance, limiting the diagnostic tests and prescription drugs they may order and limiting referrals to specialists and the emergency room.[29] As one commentator explained:

> This trend toward corporate control is eroding the foundation of the physician-patient relationship. This erosion is primarily caused by managed health care plans exercising a significant amount of economic leverage over physicians. This leverage enables health plan providers to assume substantial control over

23. David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 229 (2000) [hereinafter Hyman, *Regulating Managed Care*].

24. Corp. Health Ins. v. Texas Dep't of Ins., 215 F.3d 526, 534 (5th Cir. 2000).

25. Hyman, *Regulating Managed Care*, *supra* note 23, at 229.

26. John J. Deis, *The Unionization of Independent Contracting Physicians: A Comedy of Errors*, 36 HOUS. L. REV. 951, 954 (1999).

27. *Id.*

28. Chris Phan, *Physician Unionization: The Impact On the Medical Profession*, 20 J. LEGAL MED. 115, 116 (1999).

29. Ellen L. Luepke, *White Coat, Blue Collar: Physician Unionization and Managed Care*, 8 ANNALS HEALTH L. 275, 277 (1999); Phan, *supra* note 28, at 117. As stated above, it is the effects of utilization review on patients which dominates policy debates over managed care.

> patient medical decision-making, drive down physician incomes, and threaten the viability of some physicians' practices.[30]

In their article *Managed Care and the Physician's Marketplace*, Carol J. Simon, William D. White, Patricia Born and David Dranvoe recently noted that "[u]nder managed care the locus of decision making about where care is received and what care is obtained is shifted from individual patients and their physicians towards insurers and employers."[31] Moreover, beyond simple frustration with MCO oversight, many physicians have ethical objections to the financial incentives used by MCOs to encourage physicians to limit care.[32]

The challenge to physicians' autonomy in clinical decision making in many respects is more difficult for physicians than decreased salary. Historically, physicians have enjoyed what Magali Sarfatti Larson calls a "monopoly of competence" supported by state licensing requirements and a "monopoly of credibility with the public."[33] According to Larson, this monopoly of competence is important because "it restricts the control by outside agencies over the actual ethicality of the transaction of professional services."[34] In the view of physicians, however, managed care has invaded this previously restricted zone. As one recent study noted, more than one-third of surveyed physicians characterized their morale as low and nearly one-half stated that they often think about leaving medicine.[35] Some physicians feel that they are under siege.[36]

The economic effects of managed care on physicians are also significant. While in 1986, only forty-three percent of physicians participated with a managed care plan, by 1995, that figure had risen to eighty-three percent. This participation often puts physicians at financial risk.[37] In 1994, physician income dropped 3.8%.[38] This trend continues.[39] Indeed, in a recent article,

30. Phan, *supra* note 28, at 117 (footnote omitted).

31. Carol J. Simon et al., *Managed Care and the Physician Marketplace*, *in* MANAGED CARE AND CHANGING HEALTH CARE MARKETS 96 (Michael A. Morrisey ed., 1998).

32. *See* Daniel P. Sulmasy, O.F.M., M.D., Ph.D., et al., *Physicians' Ethical Beliefs About Cost-Control Arrangements*,160 ARCHIVES INTERNAL MED. 649 (2000).

33. MAGALI SARFATTI LARSON, THE RISE OF PROFESSIONALISM: A SOCIOLOGICAL ANALYSIS 38 (1977).

34. *Id.*

35. *Most Doctors Oppose Managed-Care Hassles*, MODERN HEALTHCARE, Sept. 21, 1998, at 38.

36. Joseph Bernstein, M.D., M.S., *Topics in Medical Economics: Lessons of the Prisoner's Dilemma*, 82-A J. BONE & JOINT SURGERY 595, 595 (2000).

37. Fred J. Hellinger, *The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence*, 53 MED. CARE RES. REV. 294, 295 (1996).

38. WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 73 (1998).

39. *See Vitals*, MODERN PHYSICIAN (June 1, 1999), *at* http://www.modernphysician.com/archive/article.php3?refid=1000 ("Median net income for doctors dropped for the fourth consecutive year in 1997, according to the American Medical Association."); *see also* Anita J.

Daniel R. Roach states that "providers are fighting for their lives."[40] Physicians who are now forced to participate with MCOs face "deselection" (termination from the plan) if they do not contain health care costs in line with MCOs market-driven strategy.[41] This termination is made even swifter because MCOs commonly include termination-without-cause provisions in their contracts. [42] Some plans even include indemnification provisions as part of their contracts, which shift liability and hold the plan harmless for its acts.[43] In describing providers' inability to comply with burdensome federal Medicare regulations, Roach cites their lack of resources. He states:

> Physicians are . . . extraordinarily frustrated with the current state of affairs as their incomes are plummet[ing] and their job satisfaction declines. In California, 115 physician groups have either declared bankruptcy or gone out of business in the last three years. An estimated eighty-five percent are in serious financial trouble.[44]

The effects of managed care on physicians are trickling down to impact medical students, and even students considering careers in medicine.[45]

Physicians' reactions to managed care largely have been dismissed as the inevitable anger over loss of professional dominance, income and prestige. One commentator recently remarked that "[i]t has been said that a good drama requires victims, villains, and heroes. If so, the managed care backlash has been a most excellent drama, with . . . providers playing the victims . . . ."[46] Such a view, however, fails to consider the level of commitment most physicians have to serving their patients, the training involved in becoming a physician and the extraordinary responsibilities a practicing physician undertakes.[47] As stated by Larson: "[I]n a secularized society, medicine serves most directly the 'sacred' value of life."[48] She further notes that "of all the

Slomski, *How Much are Groups Paying Their Doctors?*, MED. ECON., Jan. 10, 2000, at 115, 119 ("Specialists will see their salaries decrease as they reach *their* workweek limit.").

40. Daniel R. Roach & Cori MacDonneil, *The Compliance Conundrum*, 32 J. HEALTH & HOSP. L. 565, 568 (1999).

41. Richard S. Liner, *Physician Deselection: The Dynamics of a New Threat to the Physician-Patient Relationship*, 23 AM. J. L. & MED. 511, 512-13 (1997).

42. *Id.*

43. *See* Corp. Health Ins. v. Texas Dept. of Ins., 215 F.3d 526 (5th Cir. 2000). Several states have passed legislation to protect physicians from retaliatory deselection and the indemnification provisions commonly found in MCO-physician contracts. A Texas statute recently was upheld against an MCO challenge that it was preempted by ERISA. *Id*. at 536-37.

44. Roach, *supra* note 40, at 568.

45. Greenberg, *supra* note 11, at 1531.

46. Hyman, *Managed Care at the Millenium*, *supra* note 4, at 1068.

47. *See* Phan, *supra* note 28, at 116 ("Physicians, on the whole, have the longest educational and specialty training path of any professional.").

48. LARSON, *supra* note 33, at 38-39.

professions, it appears to have the strongest claims to an ideal of service and devotion to human welfare."[49]

C. The Current Legal Climate—Antitrust and Labor Laws

Most physicians are unable to take collective action to counteract the effects of managed care. Physician unionization is prohibited by the antitrust laws, which apply to collective action by sellers or purchasers of goods and services to restrain trade through such means as, for instance, price fixing.[50] Specifically, the Sherman Act "seeks to safeguard competition by assuring that market participants do not injure consumers by making agreements that illegally restrain trade."[51] The Clayton Act, on the other hand, provides an exemption to the antitrust laws by allowing labor unions to collectively bargain on behalf of their members.[52] The National Labor Relations Act ("NLRA") builds on the Clayton Act by further defining the labor exemption from the antitrust laws and establishing the National Labor Relations Board.[53]

Physicians who are employed by the federal government, hospitals or health maintenance organizations, for example, are covered by the Clayton Act and therefore, in general, are permitted to bargain collectively.[54] Employed physicians have had difficulty organizing, however, in that they are frequently considered to be independent contractors or supervisory employees and are, thus, exempt from the NLRA.[55] Approximately fifteen percent of all patient care physicians are employed and eligible to join unions.[56] It is the remaining majority of physicians, those in private practice, to whom federal physician unionization legislation would apply.

III. THE UNIONIZATION PROPOSAL

A. The Quality Health Care Coalition Act

Originally introduced by Representative Tom Campbell (R-Ca.), along with over one hundred co-sponsors, the Health Care Act's stated purpose is to

> ensure and foster continued patient safety and quality of care by making the antitrust laws apply to negotiations between groups of health care professionals and health plans and health insurance issuers in the same manner as such laws

49. *Id.*
50. *See* Edward B. Hirshfeld, *Physicians, Unions, and Antitrust*, 32 J. HEALTH L. 43 (1999).
51. Luepke, *supra* note 29, at 282.
52. *Id.*
53. *Id.*
54. Hirshfeld, *supra* note 50, at 51.
55. Luepke, *supra* note 29, at 282-83.
56. Julie Rovner, *USA Takes First Steps to a Doctors' Union*, 354 LANCET 54 (1999).

> apply to collective bargaining by labor organizations under the National Labor Relations Act.[57]

Thus, the bill's main provision states:

> Any health care professionals who are engaged in negotiations with a health plan regarding the terms of any contract under which the professionals provide health care items or services . . . shall, in connection with such negotiations, be entitled to the same treatment under the antitrust laws as the treatment to which bargaining units recognized under the National Labor Relations Act are entitled in connection to such collective bargaining. Such a professional shall, only in connection with such negotiations, be treated as an employee engaged in concerted activities and shall not be regarded as having the status of an employer, independent contractor, managerial employee, or supervisor.[58]

Significantly, the proposed legislation does not provide physicians with the right to go on strike and stop treating patients. Moreover, the statute would not apply to negotiations pertaining to federal programs such as Medicare and Medicaid. The proposed legislation also includes a three-year sunset provision.

Shortly after it was introduced, the AMA voted to endorse unionization to "give America's physicians the leverage they now lack to guarantee that patient care is not compromised or neglected for the sake of profits."[59] Since that time, there has been considerable movement on the state level, with seventeen states considering collective negotiation bills.[60] Only the District of Columbia bill has passed, however, and that measure currently awaits Congressional approval.[61] Texas is the only state with a collective bargaining statute in effect.[62] The Texas statute is instructive. In its "Findings and Purposes," the legislature stated:

> Although the legislature finds that joint negotiations over fee-related terms may in some circumstances yield anti-competitive effects, it also recognizes that *there are instances in which health plans dominate the market to such a degree that fair negotiations between physicians and the plan are unobtainable absent any joint action on behalf of physicians.* In these instances, health plans have the ability to virtually dictate the terms of the contracts they offer physicians.[63]

The statute authorizes physicians to jointly negotiate with health plans in all instances with respect to certain terms, such as "practices and procedures" for

57. The Quality Health Care Coalition Act of 1999, H.R. 13041, 106th Cong. (1999).

58. *Id.*

59. Rovner, *supra* note 56, at 54 (quoting AMA Board Chairman Randolph Smoak, M.D.).

60. Leigh Page, *State Legislatures Cool to Collective Negotiation Bills*, AM. MED. NEWS (June 26, 2000), *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_00/gvsa0626.html.

61. *Id.*

62. *Id.*

63. TEX. INS. CODE ANN. art. 29.01 (Vernon 2000) (emphasis added).

improving the delivery of health care.[64] Unlike the proposed federal legislation, the Texas statute provides that collective negotiation is not permitted with respect to fees, unless the attorney general makes a determination that the health plan has "substantial market power."[65] The statute is effective until September 1, 2003.[66]

B. The Unionization Debate

In evaluating physicians' hypothetical claim,[67] it also is helpful to examine the unionization debate itself. The arguments that are made, and those that are not made, for and against the unionization proposal, shed important light on physicians' role in our drive to reform health care. An analysis of the debate provides support for a claim that physicians are to some degree being exploited.

1. Arguments for the Legislation

One might expect physicians to support the Health Care Act on the basis that managed care has had a dramatic effect on their salaries, working conditions and the very essence of their "physicianhood." Yet arguments for legislation center not on this point, but on harm to *patients*. Advocates argue that the "tremendous control" MCOs exert over physicians has "adverse effects" on patient care.[68] During hearings on the Health Care Act, William W. Tipton, Jr., M.D., speaking on behalf of the American Association of Orthopedic Surgeons, stated that the problem, in many ways, lies in the ever-increasing consolidation of the health insurance industry.[69] Dr. Tipton stated:

> [T]hrough consolidation, health plans not only gain market power, but economic strength as well. As a result, they have been able to join together, not to negotiate or discuss contracts with physicians, but to dictate the terms of their contracts on a "take it or leave it" basis. They have been able to impose

64. *Id.* art. 29.04.

65. *Id.* art. 29.06(a).

66. *Id.* art. 29.01.

67. It is beyond the scope of this paper to analyze whether physician unionization is generally "good policy." Whereas physician unionization might not be good policy for ensuring quality patient care, as opponents to the legislation argue, it might be very effective in restoring physicians' autonomy over treatment decisions and guaranteeing what physicians regard as a fair level of compensation. This paper does not resolve these issues.

68. *Statement of the American Association of Orthopedic Surgeons on the Quality Health Care Coalition Act of 1999 before the House Judiciary Comm.: Hearing on H.R. 1304 Before the House Comm. on the Judiciary*, 106th Cong. 1 (1999) (statement of William W. Tipton, Jr., M.D., Executive Vice-President of the American Association of Orthopedic Surgeons) [hereinafter *Tipton Statement*].

69. *Id.*

> contract terms, which often are not in the best interest of patients, in order to maximize their profits and minimize their patient care responsibilities.[70]

Dr. Tipton went on to explain that many of these "take-it-or-leave-it" contracts restrict the ability of patients to receive necessary care by giving the plans veto power over physicians' medical decisions,[71] restricting referrals to specialists and imposing burdensome administrative requirements that act to delay care.[72] Dr. Tipton also noted that many health plan contracts contain "hold harmless" clauses, which give plans malpractice immunity and shift liability completely to the physician even though the plan may have dictated the treatment decision.[73] Dr. Tipton concluded by arguing that passage of the Health Care Act would give physicians the power to have input into "how health care is delivered in this new era of managed care."[74] This power, he argues, "will help restore the role of physicians as the patient's best advocate."[75]

The AMA, in its statement on the Health Care Act, also stressed that the legislation was needed to ensure quality patient care.[76] The AMA went into great detail about the consolidation of the health care industry and how this type of market concentration is harmful to patients. The AMA stated that the Aetna/U.S. Healthcare plan had "dangerous levels of control" in several states.[77] The AMA stated that since 1996, Aetna has acquired not only U.S. Healthcare, but also NYL Care and has announced its intention to purchase Prudential, resulting in Aetna having 22.4 million covered lives.[78] The AMA argued that "Aetna's extremely aggressive and anti-patient business practices . . . actually work to significantly increase its market power. Aetna's growth and profitability is not about popularity and success as a result of high quality health care, it's about aggressively purchasing market share."[79] The AMA also noted that the Federal Trade Commission and the Department of Justice had not taken actions against health care plans, despite the "tremendous consolidation" that has taken place.[80] The AMA asserted that this was in stark contrast to the aggressive action taken against physicians in the form of

70. *Id.*

71. *See AMA Statement*, *supra* note 9, at 7 ("[T]ypical examples of egregious contract terms are as follows: . . . 'Medical *necessity* means the SHORTEST, LEAST EXPENSIVE, OR LEAST INTENSE LEVEL of treatment, care or service rendered, or supply provided, as determined by us [health plan]'" (alteration in original).

72. *Tipton Statement*, *supra* note 68.

73. *Id.*

74. *Id.*

75. *Id.*

76. *See AMA Statement*, *supra* note 9, at 3-4.

77. *Id.* at 4.

78. *Id.*

79. *Id.*

80. *Id.* at 6.

antitrust investigations, evidencing what the AMA calls "a bias against physicians and in favor of payers."[81]

2. Arguments Against the Legislation

Opponents of the Health Care Act are extremely skeptical of physicians' arguments on behalf of patients and their promises to improve patient care. The American Association of Health Plans ("AAHP"), in its testimony before the House Judiciary Committee, stated that "[the Health Care Act] will benefit physicians, not consumers."[82] Indeed, opponents' arguments focus on competition and the free market, and state that giving physicians "unprecedented collective bargaining rights" will only injure consumers, not protect patients.[83]

Opponents repeatedly stressed the importance of the free market. The AAHP stated that "vigorous enforcement of antitrust laws is crucial to preserve and ensure competition in the health care marketplace."[84] The AAHP challenged physicians' assertions that health plans have dominant power, stating that there is "significant" competition among health plans.[85] The AAHP stressed that it is aware of physicians who are guilty of anti-competitive behavior, stating that "a great deal of . . . anti-competitive conduct still occurs today and the antitrust enforcement agencies have devoted substantial resources to protecting consumers from it."[86] The AAHP asserted that "physicians do not need antitrust exemptions to address quality of care issues," as health plans had "a variety of mechanisms in place that allow—and in fact encourage—physicians to contribute to efforts to improve quality of care."[87]

The government, through the Department of Justice and the Federal Trade Commission, echoed these "free market" arguments.[88] Joel Klein, Assistant Attorney General and Head of the Antitrust Division, stated in testimony before Congress:

> As in other markets, the goal for health care markets should be to ensure that consumers benefit from a competitive marketplace where neither buyers nor sellers unlawfully exercise market power. Policy should focus on ensuring that there is a competitive marketplace where neither health insurance plans nor

81. *See AMA Statement*, *supra* note 9, at 7.

82. *The Quality Health Care Act of 1998, Hearings on H.R. 4277 Before the Comm. on the Judiciary House of Representatives*, 105th Cong. 73-79 (1998) (statement of Steven J. Demontmollin, Vice President and General Counsel, Av-Med Health Plan, on behalf of the AAHP) [hereinafter *AAHP Statement*].

83. *Id.*

84. *Id.* at 78.

85. *Id.*

86. *Id.*

87. *AAHP Statement*, *supra* note 82, at 78.

88. *Id.* at 73-79.

> health care professionals are able to obtain or exercise market power to distort the competitive outcome . . . permitting providers to form bargaining groups in response to perceived bargaining leverage by insurers will not decrease the cost of health care or increase the quality of patient care.[89]

Klein stressed that the Health Care Act would thus only serve to increase costs to consumers and the government. He stated that "providers have their own self interests, and our enforcement actions and other experience suggest that their actions may not be congruent with the interests of consumers."[90] He concluded by stating:

> The better approach is to empower consumers by encouraging price competition . . . and ensuring effective antitrust enforcement both with regard to buyers (health insurance plans) and sellers (health care professionals) of provider services. Competitive issues are best dealt with in a manner which promotes competition, not retards competition, as this bill would do if enacted.[91]

Robert Pitofsky, Chairman of the Federal Trade Commission, supported these arguments and stated that "this extension of the labor exemption is being offered as a way to remedy matters that collective bargaining was never intended to address . . . collective bargaining rights are designed to raise the incomes and improve working conditions of union members."[92] He went on to state that patient care issues are important, but an "ill-fitting" labor exemption is not the right approach.[93] He asserted that if physicians had collective bargaining rights, "we can expect prices for health care services to rise substantially." [94]

The arguments for and against the Health Care Act shed considerable light on physicians' position in the current health care crisis. Because the physician culture does not encourage advocacy on their own behalf, and because physicians likely understand that such advocacy would not be well received, they center their argument for collective bargaining rights on concern for patients. This sets physicians up for the easy attack that the legislation is really about protecting physicians. Indeed, the AAHP's arguments, furthered by the government, that the Health Care Act would lead to increased physician fees is probably correct. Opponents stress that physicians' incomes are simply high

89. *The Quality Health Care Act of 1999: Hearings on H.R. 1304 Before the House Judiciary Comm.*, 106th Cong. 1 (June 22, 1999) (statement of Joel I. Klein).

90. *Id.*

91. *Id.*

92. *The Quality Health Care Act of 1998, Hearings on H.R. 4277 Before the Comm. on the Judiciary House of Representatives*, 105th Cong. 73-79 (1998) (statement of Hon. Robert Pitofsky, Chairman, on behalf of the F.T.C.) [hereinafter *F.T.C. Statement*].

93. *Id.*

94. *Id.*

enough. They do not, however, explain why.[95] This notion that physicians are fairly compensated and should not advocate on their own behalf provides a background for physician exploitation.

The health care debate also highlights the fact that in many ways, physicians are caught in a game where the rules have changed dramatically. Physicians are not trained to view health care as simply another "good" or "service." For the physician, a career in medicine is a calling, not a job. The delivery of health care involves moral and ethical complexities that do not surround the delivery of typical consumer goods and services. Yet the opponents to collective bargaining do not speak in these terms. Instead, they speak in the more comfortable terms of the market: we are dealing with "consumers," not "patients," and "providers," or "sellers," instead of "physicians."[96] The opponents have in many ways used this "market metaphor"[97] to cast physicians as anti-competitive actors in what is supposed to be a free market for health care. In our capitalist society, "free market" arguments are powerful. This rhetoric provides the background for physician exploitation.

IV. CAN PHYSICIANS STATE A MORAL CLAIM FOR COLLECTIVE BARGAINING RIGHTS?

A. Elements of Exploitation

In considering whether physicians can state a moral claim to collective bargaining rights, it is important to explain the moral theory under which they might proceed. In this case, theories of exploitation are instructive since such theories traditionally are at the root of drives to unionize.[98] Moreover, "exploitation, or one of its legal analogues, increasingly forms a basis for social and legal policy determinations with respect to a wide range of issues."[99] Exploitation can form the basis for a moral claim not simply to invalidate a

95. Opponents instead argue that physicians' income and their "anti-competitive behavior" are in large part responsible for the current health care crisis, although studies show that this is not the case. *See* Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, 6 J. OF ECON. PERSP. 3, 8 (1992) ("Those who emphasize supplier-induced demand as a factor in the expenditure increase argue that as physician supply has grown, physicians have increased demand to protect their incomes . . . . The evidence, however, does not offer much support to the view that supplier-induced demand is important in the rate of change.").

96. *See* George J. Annas, J.D., M.H.P., *Reframing the Debate on Health Care Reform by Replacing our Metaphors, reprinted in* THREE REALMS OF MANAGED CARE, SOCIETAL, INSTITUTIONAL, INDIVIDUAL 68-69 (John W. Glaser & Ronald P. Hamel eds.,1997).

97. *See id.* at 67-69.

98. *See* JACK BARBASH, THE PRACTICE OF UNIONISM 407 (1956).

99. John Lawrence Hill, *Exploitation*, 79 CORNELL L. REV. 631, 635 (1994) (footnote omitted).

particular transaction, but, as Alan Wertheimer argues, to call attention "to the injustice or wrongness of the conditions under which it is rational for B to accept A's proposal, and with arguing for the repair of those conditions."[100] This is the case here, where physicians are not seeking legislation to invalidate their transactions with MCOs, but instead seek unionization to repair or restructure the "background conditions" under which the two sides deal.

Wertheimer defines exploitation as a transaction where one party, A, takes unfair advantage of another party, B.[101] This unfair advantage must result in a gain for A.[102] Wertheimer further explains that a transaction is "unfair" where A's benefit is excessive, relative to the benefit to B, or A "has been able to turn some characteristic of B or some feature of B's situation to his or her advantage."[103] Wertheimer asserts that exploitation can take place even in "mutually advantageous" transactions where the exploitee, as well as the exploiter, gains something from the transaction.[104] Exploitation may also be present where a transaction is seemingly consensual—that is, the exploitee appears to have given voluntary, informed consent.[105]

At first glance, an exploitation claim by physicians would seem to lack merit. Physicians, traditionally thought of as societal elites, do not fit the Marxist image of an exploited worker. Admittedly, physicians receive some level of reimbursement from MCOs, and maintain some control over patient care. Their salaries are substantially higher than those of typical blue-collar workers. However, this does not mean necessarily that they cannot be exploited. Using Wertheimer's elements of exploitation, and viewing the case against managed care in the light most favorable to physicians, it is apparent that physicians could state a hypothetical exploitation claim against MCOs. MCOs in many cases do take unfair advantage of physicians. MCOs both excessively benefit from their transactions with physicians and, most importantly, MCOs are currently able to turn characteristics of physicians' situation to their own advantage.

As described above, managed care has had significant effects on physicians' working conditions and incomes. As a result, an argument can be made that MCOs benefit excessively from their transactions with physicians,

100. Alan Wertheimer, *Remarks on Coercion and Exploitation*, 74 DENV. U. L. REV. 889, 904 (1997) [hereinafter Wertheimer, *Remarks on Coercion*].

101. ALAN WERTHEIMER, EXPLOITATION 207 (1996) [hereinafter WERTHEIMER, EXPLOITATION].

102. *Id.* at 209.

103. *Id.* at 16.

104. *Id.* at 216. There is disagreement in the philosophical literature on this point. Some argue that a transaction between A and B can only be exploitative if it is harmful to B. *See* Wertheimer, *Remarks on Coercion*, *supra* note 100, at 897. Others agree with Wertheimer's formulation. *See* ANDREW LEVINE, ARGUING FOR SOCIALISM 66-70 (1988).

105. *See id.*

relative to the benefit to physicians. Through utilization review and other cost-cutting strategies, MCOs are realizing at least some financial gains, due in large part to decreased reimbursements to physicians and the health plans' own increasing market power.[106] As noted by Simon and her co-writers: "Under traditional fee-for-service indemnity policies, most patients have been insulated from the true price of care because of the prevalence of comprehensive benefits and low co-payments and deductibles. In contrast, managed-care plans realize the full amount of any cost savings."[107] This same study noted that in 1994, specialists in markets that had high levels of managed care penetration suffered a drop in earnings of nearly eleven percent.[108] The study's findings "suggest that the spread of managed care is significantly altering the relative compensation and employment of primary care and specialist physicians."[109] Thus, any benefit to physicians from their transactions with MCOs appears slight.

In contrast, the earnings of MCO executives are on the rise. A 1998 report noted that senior executives of the nation's largest for-profit MCOs earned an average of two million dollars per year.[110] One recent report found that "on average, CEO's for HMO's and other health care companies receive two-thirds more compensation than their counterparts in other industries."[111] The same report noted that salary increases for managed care executives such as chief marketing officers, chief financial officers, as well as chief executive officers, were greater than that for practicing physicians. Indeed, employees at all levels of managed care organizations saw greater pay increases than physicians during the period 1996-2000.[112] It is argued that such high salaries and generous bonus packages are justified by market principles—it is simply what

106. Managed care's impact on providers is not limited to physicians. For instance, the Association of American Medical Colleges ("AAMC") recently published a report using data from the Medicare Payment Advisory Commission, detailing the significant deterioration in the financial health of teaching hospitals. The report concluded that this deterioration was linked in part to "the growth of managed care." AAMC Fact Sheet, *The Financial Health of Teaching Hospitals Continues to Decline* (May 2000), *available at* http://www.aamc.org/about/progemph/camcam/factshts/vo14_no3.html. A 1997 study, also by the AAMC, concluded that "medical schools in regions with high levels of managed care penetration have experienced slower growth in the size and number of research awards received from the National Institutes of Health (NIH)." AAMC Fact Sheet, *Is Managed Care Affecting the Research Mission of Law Schools* (July 21, 1997), *available at* http://www.aamc.org/about/progemph/camcam/factshts/no12.html.

107. Simon, *supra* note 31, at 96.

108. *Id.* at 111.

109. *Id.* at 116.

110. Aside from the question of whether MCOs exploit physicians, MCO executive compensation poses significant ethical issues in itself. *See* KAREN G. GERVAIS & DOROTHY E. VAWTER, ETHICAL CHALLENGES IN MANAGED CARE 171 (1999).

111. *Health Care Executives Most Highly Compensated*, MANAGED CARE, May 1999, at 17.

112. *Id.*

is necessary to attract the best individuals.[113] Yet many who make these arguments do not apply these same principles to physician compensation. Perhaps they do not have to. Perhaps it is something besides compensation that attracts physicians to the practice of medicine. If so, MCOs are able to exploit physicians by capitalizing on this "something else" and paying them less than a fair rate of return for their services. Further, given physicians' training, ethical obligations and potential liability, a legitimate claim can be made that it is they, and not exclusively MCOs, who should profit from the provision of health care.

Second, and often most significant for physicians, are the benefits MCOs reap from having respected physicians as part of their plans, such as attracting and treating patients. As Larson notes, because of the medical profession's "devotion to human welfare," it has accumulated "a massive capital of social credit."[114] In effect, MCOs are successfully trading on that social credit and the trust that the public puts in physicians, and they are using it for their own gain, whether in the form of profits, market power or reputation.[115] Indeed, MCOs are exploiting physicians by reducing their social credit and are eroding their professionalism by using them as agents to ration care and not compensating them for it. This exploitation is even more apparent given that physicians invest a great deal of time and resources in becoming physicians. Because of their specialized training and investment in becoming professionals, they cannot (and in some cases will not) easily leave the profession.[116]

Finally, an argument can be made that excessive benefits to MCOs arise from their use of "take-it-or leave-it" contracts. First, most standard MCO contracts include provisions which penalize physicians if their utilization of medical services exceeds a predetermined level, regardless of whether the care provided was in fact medically necessary.[117] Thus, "MCOs have significantly shifted the financial risk of treating patients to the physicians."[118] Second, MCO standard form contracts are unfair and excessively benefit MCOs because they often contain termination-without-cause provisions that "allow MCOs to deselect physicians at any time if profit-maximizing policies are not

113. GERVAIS & VAWTER, *supra* note 110, at 176.

114. LARSON, *supra* note 33, at 39.

115. ROBBINS, *supra* note 15, at 78.

116. It may be that in the future, the conditions which enable physicians to be exploited may be mitigated by the fact that students entering the profession will have notice of the conditions under which they will be expected to perform. For mid-career physicians, however, this is not the case.

117. John P. Little, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Care*, 49 RUTGERS L. REV. 1397, 1414 (1997).

118. *Id.*

followed."[119] The threat of deselection for most physicians is significant, given MCO's market power. Finally, MCO standard form contracts excessively benefit MCOs because most contain "hold harmless" clauses.[120] As the AMA stated: "No reasonable person would, unless compelled, accept a contract which allows one party to behave in ways that may not meet the standard of care in tort law, and then shifts liability for that conduct from the responsible party to the person accepting the contract."[121] At least one commentator has argued that given these clauses, MCO-physician contracts are contracts of adhesion, which MCOs are able to use to their advantage. As such, it has been argued that such contracts are unfair and violate public policy.[122] These features of the MCO-physician relationship supply the requisite "unfairness" to support a claim of physician exploitation.

Physicians also can show the requisite unfairness to support an exploitation claim because MCOs are able to turn certain features of physicians' role in our health care system to MCOs' advantage. These characteristics will be examined below.

B. The "Free Market" for Health Care is Not Free at All

As seen in the debate over the Health Care Act, one of the features of physicians' situation used most skillfully by MCOs, with the full support of the government, are the "market imperfections" or "market failures" that led to an explosion of health care costs.[123] By pointing a finger at physician salaries and utilization habits as indicia of inefficiency, MCOs are able to use the "market metaphor" to exploit physicians. As George Annas argues:

> The market metaphor leads us to think about medicine in already familiar ways: emphasis is placed on efficiency, profit maximization, customer satisfaction, the ability to pay . . . and competitive models. The ideology of medicine is displaced by the ideology of the marketplace.[124]

Yet the "free market" for health care, which the government and MCOs purport to defend and promote, is not so free at all. The government is a major market participant, and numerous laws shape the way our health care system operates. Upon closer examination, it is apparent that the competitive, "free market" health care system we now have is in many ways a system that works to protect government and corporate interests.

119. *Id.* at 1416.
120. *Id*. at 1418.
121. *AMA Statement*, *supra* note 9, at 9.
122. *See* Little, *supra* note 117, at 1421.
123. *See generally AMA Statement*, *supra* note 9.
124. Annas, *supra* note 96, at 68-69.

Cass Sunstein, in his book *Democracy and the Problem of Free Speech*,[125] makes a similar argument with respect to the First Amendment. In arguing for a change in the jurisprudence of free speech, Sunstein proposes a "New Deal" for speech modeled on the New Deal of the Roosevelt Era. Sunstein states that before the New Deal period, the Constitution "frequently prohibited the government from interfering with existing distributions or rights and entitlements."[126] The prevailing view was that government must be neutral and take a "laissez-faire" approach, and therefore, respect the existing distributions.[127] New Deal reformers, Sunstein points out, argued that this "neutrality" was a fiction. Sunstein states that the New Deal reformers' view was that "people, rather than nature, had created economic markets and existing distributions. Laws underlay markets and made them possible. If they had good reasons for doing so, people might change those markets and existing distributions."[128] To illustrate the effect that people, and not nature, had on existing entitlements and distributions, Sunstein states that New Deal Reformers pointed out that legal rules, such as those involving property and contracts, had produced certain "entitlements."[129] Sunstein explains:

> Those rules specified who owned what and who could do what to whom. All this was a creation of law. The market system, so often described as the realm of purely voluntary interactions, was actually pervaded by law . . . what people had, in markets, was a function of the entitlements that the law conferred on them. The notion of "laissez-faire" thus stood revealed as a conspicuous fiction.[130]

This argument applies with equal force here. The rhetoric of health care reform is centered mostly on solving the current crisis through enhanced competition and a "free market" approach. Yet, proponents have not changed the existing legal framework that shapes our health care system—a framework that arguably exploits physicians. As Annas argues:

> [T]he market metaphor is . . . a myth . . . . The metaphor pretends there is such a thing as a free market in health insurance plans and that purchasers can and should be content with their choices . . . the reality is that American markets are highly regulated [and] major industries enjoy large public subsidies . . . .[131]

Thus, far from unleashing efficiency-enhancing competition, the managed care "solution" in many ways has worked simply to further the interests of certain

125. CASS SUNSTEIN, DEMOCRACY AND THE PROBLEM OF FREE SPEECH (1995).
126. *Id*. at 29.
127. *Id*.
128. *Id.* at 30.
129. *Id*.
130. SUNSTEIN, *supra* note 125, at 30–31.
131. Annas, *supra* note 96, at 69.

powerful players in the health care system: the government and corporations which purchase health care coverage.

The government's involvement in the health care market is not simply through the laws it makes and enforces—it is a large purchaser of health care services through the Medicare and Medicaid programs. Spending on health care has a significant impact on the federal budget. In 1991, 14.3% of the federal budget went to health care.[132] In 1996, Medicare and Medicaid programs paid between forty-five and fifty percent of personal health expenditures.[133] At least one commentator has noted that "the self-interest of the public sector may be a real impediment to development of a fair and efficient supply-side cost sharing policy . . . . Governments do not simply set the rules of the game in health care, they are big players themselves." [134]

Indeed, the government is not simply a major purchaser of health care; in many ways, it constructed the system that led to the "market inefficiencies," which are frequently cited as justifying lower and lower reimbursements to, and more controls over, physicians. For instance, the government, at a minimum, encouraged the current health insurance system where most employed, insured individuals receive their health insurance through their employer.[135] Because health benefits are not taxable to the employee, the system provides corporations and their workers with generous tax subsidies.[136] This employer-based system is what many believe started the managed care revolution—employers did not want to continue paying high insurance premiums for their workers.[137] As Rosenblatt notes:

> [T]he law provided two types of assistance to the managed care revolution. First, on the "demand" side of the . . . equation, ERISA . . . permitted employers to bypass . . . a provider-dominated insurance system in favor of self-funded plans that avoided provider-dominated fee structures and content rules . . . . Second, the law aided the transformation to managed care from the supply side of the equation, as well . . . . U.S. market law favors vertical integration and the formation of a single large producer of goods and services [and] . . . the movement toward the formation of large companies selling discounted health services to unregulated corporate purchasers took off.[138]

132. JUDITH AREEN, ET AL., LAW, SCIENCE AND MEDICINE 814 (1996).

133. WING, *supra* note 22, at 88.

134. Randall P. Ellis & Thomas G. McGuire, *Supply-Side and Demand-Side Cost Sharing in Health Care*, 7 J. OF ECON. PERSP. 135, 149-50 (1993).

135. Hyman, *Regulating Managed Care*, *supra* note 23, at 225.

136. WING, *supra* note 22, at 99.

137. Hyman, *Regulating Managed Care*, *supra* note 23, at 227. *See also AAHP Statement*, *supra* note 82, at 76. ("The antitrust laws and antitrust enforcement have played a historic and special role in the development of managed care as an alternative to fee-for-service medicine for consumers.").

138. ROSENBLATT, *supra* note 16, at 550 (citation omitted).

In addition, reimbursement levels set by the government for the Medicare program are often the basis for an MCO's determination of "reasonable" fees.[139] As one commentator remarked, "while managed care may have its roots in populism, the model has flowered in the favorable climate created by the American approach toward deregulation and corporatization."[140]

C. Physicians Cannot Openly Advocate for Themselves

A second feature of physicians' situation, which MCOs use to gain an unfair advantage, is that physicians are limited in their ability to advocate for themselves. As explained above, physicians have not advocated for collective bargaining rights on the basis that they are being exploited. That they are not, however, is one reason why MCOs and the government are able to exploit them. At first blush, this statement likely seems ridiculous. It is widely known that the AMA is a very powerful lobbying organization. Outside of the AMA, physician specialists have their own lobbying organizations. Yet the physician unionization debate reveals that physicians are indeed limited in how and how much they can advocate for themselves by their ethics, by fear of malpractice liability and by an unsympathetic society.

As a group, physicians take very seriously their ethical commitment to place patients' needs first. As Dr. Andrew Yacht recently stated: "[T]he needs of our patients must always come before our own desires and other responsibilities . . . . At a time when the needs of patients have become dangerously obscured by financial considerations, we need to do what we can to protect those for whom we have sworn to care."[141] As noted above, in arguing for unionization, physicians cast it as an issue of patient care.[142] Indeed, physicians seeking unionization have disavowed, as unethical, one of the primary tools used by unionized workers—strikes.[143] Unlike other workers attempting to unionize, physicians' ethics essentially require that they argue for improved patient care first and their own wages and working conditions second (if at all). One physician has summed up the frustration physicians feel:

> [A]s a group we study more years, work longer hours, bear more crushing responsibilities, perform greater amounts of free service to our hospitals . . .

139. WING, *supra* note 22, at 541.

140. ROSENBLATT, *supra* note 16, at 550.

141. Andrew C. Yacht, M.D., *Collective Bargaining is the Right Step*, 342 NEW ENG. J. MED. 429, 431 (2000); *see also* Jordan J. Cohen, *White Coats Should Not Have Union Labels*, 342 NEW ENG. J. MED. 431, 434 (2000) ("As future stewards of medicine's core value of service to others, ask yourselves if affixing the union label to your white coats signals trust in your noble calling or allegiance to some lesser ideal. Unions are magnificent instruments for extracting marketplace benefits for their members. But the odds are long indeed that they will be able . . . to sustain a value system rooted in altruism.").

142. *See generally* Yacht, *supra* note 141.

143. *See id.*

> than any other group. We must now proclaim our right to demand appropriate payment for all of this . . . . [I]t is time we abandoned the canard that unselfish humanitarianism provides our only motivation.[144]

The fact that many physicians so readily subvert their own interests to that of their patients makes them prime targets for exploitation at the hands of MCOs.

Second, physicians cannot always take a stand for themselves by openly doing what is necessary to increase their reimbursements from MCOs, which would entail limiting care, because of their fiduciary duty to their patients.[145] The terms established by MCOs put physicians at financial risk if their patients utilize more than a pre-determined level of health care services such as referrals to specialists, emergency rooms or use of diagnostic tests, for example. If physicians want to increase their incomes, and in some cases keep their practices solvent, they are required to keep utilization to a minimum—in effect, to ration care.[146] Yet rationing care is not a part of physicians' ethical code, nor is it a defense to a malpractice claim.[147] Again, MCOs are therefore able to take unfair advantage of physicians because to some degree, physicians must provide services to patients, even if they will not get paid for it, to adhere to their code of ethics and avoid liability.[148] Moreover, despite their calls for a free and competitive health care market, which is traditionally thought to require providing consumers with reliable and full information, MCOs do not fully disclose to plan members that rationing is a significant factor in coverage as well as treatment decisions.[149] In effect, MCOs suggest to enrollees that they will provide a fee-for service level of care, while leaving the physician to bear much of the risk of delivering it.

Finally, physicians cannot openly advocate for themselves because such advocacy does not fit our current health care paradigm. We expect physicians

144. Phan, *supra* note 28, at 116 (citing G. BUDRYS, WHEN DOCTORS JOIN UNIONS 9 (1997)).

145. *See* Neade v. Portes, 710 N.E.2d 418, 424 (Ill. App. Ct. 1999); *see also* CURRAN, *supra* note 38, at 188.

146. The term "rationing" is not very often used in the public discourse on managed care (and it certainly is not part of MCOs' marketing strategy). Rationing, however, is clearly what managed care is about. The Supreme Court repeatedly stressed this in *Pegram v. Herdrich*, 120 S. Ct. 2143, 2150 (2000). The Court stated that "whatever the HMO, there must be rationing and inducement to ration . . . . [I]nducement to ration care goes to the very point of any HMO scheme . . . ." *Id.*

147. *See id.* at 2143 (holding a physician allegedly rationing care on behalf of HMO liable for malpractice). Bedside rationing without full disclosure to the patient may in at least some states support a claim for breach of fiduciary duty. *See generally Neade*, 710 N.E.2d at 427.

148. *See* Wickline v. California, 192 Cal. App. 3d 1630, 1643 (Cal. Ct. App. 1986); *see also American Medical Association Fundamental Elements of the Patient-Physician Relationship*, *available at* http://www.ama-assn.org/ethic/ceja ("[T]he physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.").

149. *Id.*

to be devoted to our welfare. Attempts to increase their incomes or improve their working conditions are therefore viewed with suspicion, as the inappropriate self-interest of wealthy elites. One commentator has stated that, with respect to managed care legislation, "the drafting of consumer protections is . . . readily hijacked by entrenched providers, who have their own interests at heart."[150] In discussing physician deselection, another commentator noted:

> Although deselection places physicians at personal risk, lawmakers are more likely to respond to the risks deselection poses to patients. Unfortunately, this leaves concerned physicians with a paradox. A promising argument against deselection requires physicians to take the self-deprecating position that fear and finance have so upset their fiduciary and ethical duty to their patients that they can no longer be trusted to provide competent health care.[151]

Clearly, society is not receptive to pleas that physicians are not paid enough or have a difficult lifestyle. Indeed, in discussing the Health Care Act, Thomas Greaney stated:

> The rationale for the labor exemption rests primarily on notions of assuring fair wages and preventing the exploitation of labor by owners of capital. At bottom then, special treatment of labor is fundamentally premised on concepts of fairness and redistribution of wealth. With physicians enjoying mean net incomes exceeding $200,000, income growth significantly higher than other sectors of the economy, and enormous educational subsidies, the case for parity of treatment is unconvincing.[152]

Even assuming that Greaney is correct regarding physicians' incomes, he is incorrect in implying that physicians are somehow per se unable to be exploited. As Wertheimer states, exploitation can be present in mutually advantageous transactions.[153] Moreover, in focusing on physicians' incomes alone, Greaney and others do not go behind the numbers to explore the complex issues of the value of health care in our society, the proper distribution of income and the proper levels of risk to be borne by those who provide health care and health insurance. To be sure, physicians are in many ways different from the traditional blue-collar worker—the vast difference in incomes being the most obvious. Yet Greaney and others who focus on physician incomes may be missing the point. Like the traditional exploited worker, physicians are increasingly disempowered in their workplace. Moreover, like the classical worker, paid just enough to subsist, we may have hit or possibly passed the point where physicians can no longer subsist as professionals given their sizeable investment in training, strict ethical

150. Hyman, *Managed Care at the Millennium*, *supra* note 4, at 1063.

151. Liner, *supra* note 41, at 518 (footnotes omitted).

152. Thomas L. Greaney, *Antitrust and the Healthcare Industry: The View from the Three Branches*, 32 J. OF HEALTH & HOSP. L. 391, n.65 (1999).

153. *See* WERTHEIMER, EXPLOITATION, *supra* note 101, at 216.

obligations and the threat of malpractice liability. Whether we are in fact at that point, and whether for the greater good we want to stay there, is something that bears further discussion.

V. CONCLUSION

Our intuition tells us that physicians are elites, and therefore they cannot be exploited. Relying on this intuition, we adopt policies which attempt to provide a health care system that gives first-quality care, at the lowest prices, delivered through a "free-market" system. As the key gatekeepers to health care, physicians are thus caught in the middle. Top-notch American health care costs money and for-profit MCOs must watch their bottom line. Rationing, therefore, is key. The issue is, assuming we have decided that free-market health care is the solution, how much should physicians have to sacrifice in the name of the greater capitalist good? This piece recognizes that physicians have a legitimate claim that in the drive to reform health care should not be overlooked.